

FORM 9

FESTIVAL NAME

GROUP NAME

Medical Authorization, Release and Waiver Agreement

Name of Participant (as it appears on Passport): _____

I hereby give my consent and authorization to allow representatives of **NAME OF GROUP**, World Projects and/or World Projects affiliates to seek any necessary medical treatment for myself during the Performance Tour, and I hereby appoint said persons as my attorney in fact to authorize medical treatment on my behalf (hereafter referred to as "Authorized Persons"). Authorized Persons may obtain medical treatment from physicians, dentists, staff, technicians and/or nurses on my behalf and may authorize the use of ambulances, paramedics, hospitals, and other medical facilities, and may authorize performance of any diagnostic procedures, treatment procedures, operative procedures, and x-ray treatment which these medical professionals determine are necessary. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the participant. I understand that I alone am responsible for the cost of any medical treatment provided for any reason, and that I alone am responsible for any and all consequences arising from or related to such medical treatment.

On behalf of myself, my heirs and my assigns, I hereby release and waive any and all claims related to my medical treatment against Authorized Persons, including but not limited to the selection of any medical, professional, or course of treatment, any authorization given or refused, any consent, failure to provide consent or measures taken or not taken to obtain medical treatment, or failure to obtain prior authorization or any other procedures required by any insurer that I may have. I understand that no person authorized to provide information or authorization is obliged to obtain medical treatment for me or to transmit medical information to any person for any reason, and that this authorization and medical history is for my own convenience. This authorization does not create any rights or obligations against any Authorized Persons, and I agree to indemnify, defend, and hold harmless any Authorized Person against any such claims arising from or related to this Authorization.

I affirmatively state that I am fit to participate in the Performance Tour, and I know of no medical condition that would prevent my full and complete participation in the Performance Tour. I understand that the rigors of travel present unexpected circumstances and opportunities for injury and disease, and that I will take all reasonable measures to protect myself and minimize my exposure to injury and/or disease. I will take adequate precautions to have an ample supply of any and all legally prescribed drugs and medications with me during the course of the Performance Tour, and will take appropriate arrangements to ensure that I am able to receive medical treatment. I will not consume any illegal substance during the course of the Performance Tour. I will alert my tour group leader immediately in the event I feel ill or am injured in any respect.

I swear that the foregoing is true and correct, and that this medical release was signed by me and (if under the age of 18) my parent or legal guardian on _____.

Signature of Participant _____

As the Parent/Legal Guardian of the participant, I provide my consent to the above Medical Authorization Release and Waiver of Claims. I adopt and accept all of the terms stated above, and by my signature give full authorization, personally and on behalf of the participant, to proceed with any act consistent with the above Medical Authorization Release and Waiver of Claims.

Signature of Parent/Legal Guardian: _____

Relationship to Participant: _____

NOTE: This Medical Authorization Release and Waiver Agreement Must Be Filled Out Completely and Signed by Parent or Guardian if Participant is Under the Age of 18.

MEDICAL HISTORY

All statements concerning my medical history, insurance information and emergency contacts in the medical history that follows are current, accurate, and complete (use additional sheets if necessary). I understand that I am required to carry a complete medical history on my person at all times during the course of the Performance Tour. The following information is a full and correct statement of my medical history:

- 1. Identify any allergies: _____

- 2. Identify any special medical problems: _____

- 3. Identify any prescription or over-the-counter drugs you are taking: _____

- 4. Identify the date of your last tetanus shot: _____
- 5. Identify the name, address and telephone number of your physicians, dentists, or any other medical professionals, hospitals, or facilities having pertinent information concerning your medical history:
 - a. _____
 - b. _____
 - c. _____
- 6. Please list three (3) emergency contacts:

Name	Relationship	Phone	Fax
a. _____	_____	_____	_____
b. _____	_____	_____	_____
c. _____	_____	_____	_____

Medical Insurance Information

- 7. Identify the name of your health care insurer: _____
- 8. Participant Number/Group Code: _____
- 9. Address and contact information for Insurer: _____
- 10. Identify any requirements for seeking pre-approval of medical treatment: _____

I swear that the foregoing is true and correct, and that this medical history was signed on _____.

Signature of Participant _____
 Signature of Parent/Guardian: _____
 Relationship to Participant: _____

NOTE: This Medical History Must Be Filled Out Completely and Signed by Parent or Guardian if Participant is Under the Age of 18.

If any additional information concerning the traveler’s medical history would be pertinent in an evaluation by medical professionals, please initial here _____ and use the next page for submitting additional information.

